

Edgewood Center for Children and Families
FY2010 Appropriations Request

Date Submitted: Monday, March 2, 2009

Project Name: Multi-generational Access to Care

Individual/Organization: Edgewood Center for Children and Families administrative offices and Campus is located at 1801 Vicente Street in San Francisco. We also have three program sites in San Mateo County located in San Carlos, South San Francisco, and San Bruno, all of which are located in the 12th Congressional District.

Amount Requested: \$500,000

Appropriations Bill/Account/Relevant Authorization law/bill/status:
Labor HHS Education and Department of Transportation

Local Contact:

Nancy Rubin, CEO
415-682-3101 / nancyr@edgewood.org

Organization's Main Activities.

The mission of Edgewood is to strengthen children, youth, families, and their communities through service, training, advocacy, and research. *We provide services to 5,000 of the most "at-risk" children, youth, and families in our communities, i.e. children who have suffered abuse and neglect, are living in poverty, whose parents are incarcerated, who are in foster care, need the support of mental health in patient programs.* Founded more than 155 years ago as a Gold Rush orphanage, Edgewood has evolved to become an innovative, multifaceted **non-profit agency**.

*In both counties, our **Kinship Support Network** supports grandparents and relatives raising children without parents through case management, therapy, workshops, and respite care for caregivers; educational and recreational programs and independent living skills for children and youth. **San Francisco Community Based Services** delivers Edgewood's *continuum of care*. **School-Based Services** operates in 30 schools: mentoring to children at risk for school failure, teacher training, family support, parenting and mental health workshops, and behavioral skills. **Intensive Services** provides accessible, community-based interventions to severely emotionally disturbed children. Abused and neglected children find a haven in our licensed Level 14 **Residential Program**, with its *full-time* staff of psychiatrists, psychiatric residents, nurses, and pediatricians. **San Mateo County Community Based Services**, delivers a wide range of services from East Palo Alto to Daly City. **Intensive Services** provides a continuum of care ranging from 24/7 support, therapeutic services for abused children and youth, and wrap-around care for adolescents to achieve independence, stability, and wellness. **Community Health Services** help families navigate the medical system, promote wellness through health screenings, and healthy-lifestyle workshops and education.*

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Please show main items in the project and total cost in a simplified chart form.

EXPENSES	AMOUNT
Campus Gym Rehab	\$400,000*
5 New Vans	\$150,000
Van Insurance, maintenance, and gas	\$6,920
5 Transportation Workers @ \$16.50/hour with Benefits at 25%	\$214,500
<i>Total Expenses:</i>	\$771,420
REVENUE	
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Herbst Foundation- <i>to be requested</i>	\$275,000
<i>Total Revenue:</i>	\$775,000

**Subject to change, based on a quote from 2005.*

Project Description, including a timeline, goals, expected outcomes and specific uses of Federal Funds.

Project Description: Edgewood seeks to build a state of the art facility and transportation system for the children and families that we serve to participate in high quality therapeutic recreation, physical, and social activities. Edgewood is fortunate to have a seven acre facility in the Sunset District that has tremendous potential. Our goal is to share not only this facility with our partner agencies but also to share successful intervention and prevention models starting with Friends of the Children (FOTC), San Francisco. FOTC brings with them their expertise in mentoring services for children beginning in the first grade and ending in high school. The goal is for 100% of the children in the program to avoid gangs, criminal activity, teen parenting, and substance abuse, graduate from high school, and enroll in college.

In order to make this intergenerational project a success we are seeking funding to remodel and transform our 1922 gymnasium and build an expanded transportation system that will ensure that are children, youth, and families have access to our services at all of our program sites. Transportation is key to insuring safety and increased participation for our families who are often living in the most impoverished neighborhoods in both San Mateo and San Francisco county. Currently both Edgewood and FOTC rely on public transportation, which in San Mateo County is very limited, and in our focused San Francisco neighborhoods is difficult to maneuver because of gang territory lines and violence. Often our grandparent caregivers place limits on the travel of their children due to fear for their safety. *Our transportation service will not only provide safe transportation to our activities, but to our daily services in San Mateo and San Francisco.*

Timeline: This timeline reflects year-round, ongoing operations and our proposed project can be implemented immediately upon receiving the award.

Activity	Time Frame
Recruit and Hire 5 Transportation Workers	3-4 months
Purchase Vans	2 weeks
Campus Gym Rehab-planning to completion	9 months-1 year

Project Goal: To transform our Campus into an intergenerational therapeutic recreational, social, and educational facility that offers access to services through door-to-door transportation.

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Expected outcomes:

DESIRED OUTCOMES	DATA OR MEASURES
Increased child and youth sense of belonging to a community.	School Age Desired Results Developmental Profile
Increased confidence in his/her ability to work as part of a team.	Banduras Self-efficacy measure;
Increased interest in exploration/curiosity	“ ”
Increased sense or personal responsibility	“ ”
Increase in perceived competence	Banduras Self-efficacy measure or Family Strengths Scale
Increase awareness and skills to reduce problem behaviors	BERS-2 (Behavioral and Emotional Rating Scale)

Specific use of funds: Edgewood respectfully requests \$500,000 to remodel our gym, hire five dedicated Transportation workers, and purchase five new vans. The gym remodel will transform our existing basketball gym into a multi-purpose room that will have the ability to double as a stage and performance area, rehearsal space, learning, tutoring, and training center with the proper acoustics, electronic wiring and capacity for overhead projections.

How will this earmark serve to expand the capacity of your organization and how will your organization sustain this work beyond the federal funding?

This earmark will allow Edgewood to take the first steps toward expanding the use of our campus for all generations. By utilizing the earmark funds to remodel our gym, purchase additional vans, and hire dedicated Transportation workers we will allow us to increase our capacity to serve more children, youth, and caregivers in our Kinship program. We currently have a wait list because all of our vans are currently at capacity in tutoring, weekend recreation services, support groups, food bank, and general access to our facilities. By increasing our capacity to bring families to and from our Campus, our San Carlos Family Center, and our two satellite office in San Mateo county we will more than double active participation in Kinship programming.

By hiring dedicated transportation workers, it will allow our program staff—who are often doubling as transportation workers—to have more meaningful and impactful relationships with our families. Often times are tutoring staff, educational coordinator, and asset coaches drive the vans to bring our families to and from our various locations. Approximately 6-10 hours per week of their time is spent on transportation, leaving only 30 hours per week to complete lesson plans, paperwork, and supportive work for our families.

The gym remodel will also allow Edgewood to increase our capacity for internal staff trainings and increase revenue by renting out the space for use by the community. Our robust Training Department brings local and national experts to our staff of over 400, trains our staff so they can in turn become an expert in the field, and offers trainings in a wide variety of topics, ensuring that our staff members learn valuable skills and cutting edge models that will go with them to future careers and will enhance the field for years to come. We also offer these trainings to our

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network of community partners and encourage them to utilize our facility for events and large ticket trainings.

What is the local significance of this project?

Many children in the Bay Area confront interlocking challenges: they are living in poverty, living without their parents, struggling with learning disabilities and mental health issues, witnessing violence, adjusting to a new country—often all at the same time. Edgewood is a safe place away from the chaos of their lives, a structured environment that does not change from day to day. This type of stability is necessary and important to a child that only knows chaos, sees violence in his or her community, or is unsure where their next meal will come from when they leave our site. Edgewood's goal to offer a healing and growth stimulating experience for both children and their families through opportunities to play and learn together will enrich the relationship of parents and caregivers to their children and increase the opportunity for children to be engaged in safe and stimulating activities.

In San Mateo County the highest number of families served by Edgewood live in East Palo Alto, Menlo Park, Daly City, South San Francisco, and Redwood City. Of the child population in the county 49% are in families earning less than \$50,000 a year, 30% receive free or reduced lunch, 44% are English language learners (highest home-languages: Spanish, Tagalog, and Cantonese). (US Census, American Community Survey, 2006) Although not considered to be below the federal poverty level, the income necessary to meet basic needs for a family of three is \$57,501. (The Preteen Alliance, A Portrait of Preteens in Santa Clara & San Mateo Counties, 2006). Only 23% of socio-economically-disadvantaged 3rd graders scored at or above the 50th percentile on the CAT for reading. Reading achievement in 3rd grade is a strong indicator for future school success, and low early performance points to increased high school dropout rates and poor college preparedness. (San Mateo County Children's Report).

In San Francisco, 15% of children and youth are living in poverty today, with the highest rates experienced by African Americans and Latinos at 36% and 18%, respectively. Although child abuse cases are down in the region, San Francisco still has the highest rate in the Bay Area—as well as the highest rate of juvenile arrests, deaths by suicide and self-injury among youth ages 15-24, and percentage of children eligible for free and reduced price lunches (57.3%). At 37%, the city has the fifth largest immigrant population in the nation, and 27% of San Francisco children and nearly 23% of San Mateo children are English language learners. Lack of safe transportation from school to services continues to be the leading barrier to access of care. Many of our children and youth living in San Francisco can not easily or safely leave their home and take public transportation to Edgewood. Because of turf and gang issues many parents and caregivers fear for their child's safety and often a bus line found on their corner can be unsafe to ride. In San Mateo county our San Carlos site, while very family friendly, is located more than a mile from public transportation. The effects of poverty, parental loss, culture shock, prenatal substance exposure, physical or sexual abuse, and living in a near-constant state of fear and uncertainty all influence a child's well-being and can perpetuate a generational cycle of school-failure, poor health, violence, and continued poverty.

Edgewood is committed to the principal that our programs will do whatever it takes to ensure that upon discharge from our services youth are welcomed into a permanent social network and

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have achieved competence in educational, emotional, and vocational skills. We provide a continuum of culturally-competent school-based, community-based, and residential services for 5,000 youth and families each year in English, Spanish, Cantonese, Mandarin, Vietnamese, and Tagalog. Our multi-generational clients can access a broad range of services at program sites in San Francisco, San Carlos, San Bruno, and South San Francisco. The creation of an intergenerational recreational facility will further provide a safe place for our families to feel connected, safe, and welcome in their community.

How many residents of the 12th CD will benefit from this project?

We anticipate active participation of more than 3,000* children, youth, and families through the following programs: Residential Treatment Services/Day Treatment/ After School Recreation and Therapeutic Program (178), Kinship Support Network-both counties (1,489), Turning Point (80), Differential Response (362), the Child Abuse and Family Treatment Collaborative (786), and Friend's of the Children (48). **Please note that client numbers only reflect the children/youth served, with the exception of Kinship, and the 3,000 serves as an estimate of secondary and tertiary clients consisting of adults, siblings, and relatives.*

Based on the potential that exists in the 12th Congressional District we anticipate that our services will be far reaching and we will only continue to grow. For example, more than 55% of San Mateo county children exiting foster care are placed with family members; of 220,266 children (up to age 24), 12,088 live with grandparents or other relatives as an alternative to foster care. In both San Francisco and San Mateo county one in six children are being raised by a grandparent or other relative, compared to nearly one in 12 children nationwide. (2006, American Community Survey). Many of our families live in the most impoverished areas of San Francisco and San Mateo county. Our Vicente Campus offers a safe space for families to receive a wide range of services free from the violence that plagues their neighborhoods and often exists outside of their front door. By providing door-to-door transportation we can ensure safety and access to our services. A family can come to our Vicente location and received tutoring for their 10 year old, a blood pressure check for themselves, peer-to-peer support, and a hot meal

Furthermore, we will create five new jobs, hire an architect and construction firm to remodel the gym, and purchase five new vehicles all of which will enable us to support the depressed economy.

List any other organizations or state/local elected officials who have expressed support for the project in writing.

Attached you will find Letters of Support from ODC Dance and Friends of the Children San Francisco.

Does the organization have any other funding requests for this project?

Edgewood is embarking on a major transformation regarding the way we provide services. This is in response to our years of work in the SF Bay Area and also to the changing economy. One of the key elements is working with all generations concurrently. Under the direction of our new Chief Advancement Officer and our Board of Directors we will be targeting a healthy mix of individual donors, foundations, corporations, and volunteers to secure the funds needed to make

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this shift. A proposal will be submitted to the Herbst Foundation in FY09/10 to help underwrite the cost of the gymnasium remodel. Edgewood submitted a proposal to KaBOOM! to be considered as the San Francisco site for the building of an intergenerational playground to be built in June 2009. This proposal is still pending. Additionally, we have received a total of six vans since 2004 through the Department of Transportation, Division of Mass Transportation, Specialized Federal Transit Branch 5310 program. We will continue to apply for this funding yearly.

Has the organization previously received Federal funds for this project?

Edgewood has been awarded a yearly grant from the FTA 5310 program that provides us with new vans based on the condition of our current vehicle fleet. We have been a recipient of this federally based program since 2004 and have received a total of six vans. We do not receive any monetary donations from this program only the physical van(s).

Please attach a list of your organization's staff and board members.

Attached you will find a list of our Edgewood and Friends of the Children Board Members and a key staff list for Edgewood's executive staff and the Executive Director of Friends of the Children.

Please attach any additional relevant materials.

Attached you will find an Article titled: "Using Art in Trauma Recovery with Children" from the American Art Therapy Association and a "Preliminary Study of an Intervention completed with our Kinship Families from the Institute for the Study of Community-Based Services, the Research Institute that is a part of Edgewood and leads all outcome and output collection for the agency.



Key Agency Staff List-Edgewood

Nancy Rubin, M.S.W., Chief Executive Officer. Prior to joining Edgewood, Ms. Rubin was the Director of the Marin County Department of Health and Human Services. In her 26-year career in public health and human services, she has served as Deputy Director and Chief of Staff at the Los Angeles County Health Department; Director of the General Relief Healthcare Program of Los Angeles County; Director of Forensic Services and Director of the Homeless Program at the San Francisco Department of Public Health.

Ken Epstein, L.C.S.W., Director of Programs and Strategy. Mr. Epstein has worked with family/caregiver and youth service programs since 1981. Prior to joining Edgewood, he served as Executive Director of Northeastern Family Institute in Vermont, as an innovator in Wraparound, Substance Abuse and Hospital Diversion Services. Mr. Epstein has served on the faculty of the Department of Psychiatry at the University of California at San Francisco (UCSF), where he has developed and directed the Family Therapy Training Program. Under his leadership over the past eight years, Edgewood has expanded its programs and developed its community- and school-based services. Mr. Epstein developed Family Conferencing at Edgewood, a vital component of our work to ensure family/caregiver centered and strength-based Services.

Robin Randall, M.D., Medical Director. Dr. Randall received his MD/MPH degree from Tulane University School of Medicine and School of Public Health. Dr. Randall has served as a consulting psychiatrist for Westside Community Services and Walden House, Inc. Dr. Randall joined Edgewood as Associate Medical Director, serving SED children, youth and their families in both intensive and community-based settings, and was promoted to Medical Director in 2002. He is a volunteer clinical faculty member at UCSF and Site Training Director for the UCSF Child and Adolescent Psychiatry Training Program.

Debra Menaker, M.B.A., Chief Financial Officer. Ms. Menaker joined Edgewood as Chief Financial Officer in 2007 with extensive experience as a nonprofit organization executive and financial leader. She oversees Edgewood's finance, human resources and technology groups. Ms. Menaker joins us from the Exploratorium after 17 years of services as the CFO where she was responsible for the financial management of a \$30 million not-for-profit science, art and human perception museum. Prior to that she served 5 years as Assistant Treasurer at LucasFilm in San Rafael and began her business career at Levi Strauss, while receiving her MBA from Pepperdine University.

Tjiska Van Wyk, Chief Advancement Officer. Ms. Van Wyk oversees all of Edgewood's fund development and communications activities including donor relations, direct mail, marketing, events, and institutional giving. With over 25 years of fundraising experience, Ms. Van Wyk has served in senior development roles for various reputable non-profit organizations including the San Francisco Zoological Society, Earthjustice Legal Defense Fund, the American Red Cross, the Sierra Club, and the American Diabetes Association.

Key Agency Staff List-Friends of the Children

Charlotte Burchard, Executive Director. Ms. Burchard has served education and nonprofit organizations for more than 30 years. She has a Master's degree in Education, a credential for teaching preschool through junior college, and an early childhood specialist credential. She worked as a teacher and administrator in public and private schools, and was a consultant for 10 years to various schools, child care centers, family service agencies, community based organizations, and parents.

Board of Directors Affiliations 2008/2009

Board Member	Affiliation
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Mia Walker
Director of Communications, Freedom from Hunger

January 2009

USING ART IN TRAUMA RECOVERY WITH CHILDREN

From the American Art Therapy Association

About Art Therapy

Art therapy can be beneficial to people of all ages, but it is especially useful for children. Art is a natural form of communication for children because it is easier for them to express themselves visually rather than verbally. This is particularly true for children who have experienced a traumatic event, such as Hurricane Katrina or other natural or man-made disasters.

Art therapists are mental health professionals specifically trained to use art with individuals of all ages who are emotionally stressed or traumatized. Members of the American Art Therapy Association hope that this information will give those working with traumatized children and their families a greater understanding of how art therapy can be used to support trauma recovery.

Art therapy is an established mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well being of individuals of all ages. It is used with children, adolescents, adults, older adults, groups, and families to assess and treat the following: anxiety, depression, and other mental and emotional problems and disorders; mental illness; substance abuse and other addictions; family and relationship issues; abuse and domestic violence; social and emotional difficulties related to



disability and illness; trauma and loss, physical, cognitive, and neurological problems; and psychosocial difficulties related to medical illness. Art therapy programs

are found in a number of settings including hospitals, clinics, public and community agencies, wellness centers, educational institutions, businesses, and private practices.

Art therapists are professionals dedicated to the belief that the creative process involved in art making is healing and life enhancing. For children, the opportunity to draw, paint, and construct with an art therapist can help them to communicate difficult issues, reduce stress, and reconcile feelings.

Understanding Children's Trauma Reactions

Children who experience catastrophic disasters and events show a wide range of trauma reactions. Some children have worries and bad memories that gradually disappear over time with emotional support of caregivers and communities. Other children may experience more long-term problems, stress reactions, and post-traumatic stress disorder (PTSD). Emotional reactions -- fear, depression, withdrawal, or anger and physical complaints or symptoms with no medical basis -- can occur immediately or appear weeks and months after the traumatic event. Worries and concern can interfere with a child's ability to pay attention and concentrate and cause difficulty in school. Loss of trust in others and fears of the tragedy happening again are common responses in many children and adolescents who have experienced a traumatic event.

1202 Allanson Road, Mundelein, IL 60060-3808 1-888-290-0878

www.arttherapy.org

Some children are more vulnerable to the effects of traumatic experiences for reasons that we still do not completely understand. For example, children who have experienced previous traumas or who already have a mental health disorder may be more susceptible than others to problems following traumatic events. Also, children who witnessed or directly experienced the disaster are believed to be more at risk than others who are less directly affected. But even second-hand exposure to a disaster (through media reports or hearing vivid stories about the event) can be traumatic for some children. A child whose caregiver is having a hard time coping with the disaster will also likely face more challenges. In all cases, children who have experienced a catastrophic disaster, such as the recent hurricane, need support from others to avoid long-term emotional problems.

Working with Emotionally Traumatized Children

- 1) Be supportive and compassionate in talking with children to help them feel safe. Children who have been displaced from their homes by a disaster, have been separated from family members, or who have lost loved ones are particularly vulnerable. Help children share in maintaining their feelings of safety by asking them about their specific needs for comfort and self-care. Help them develop a personal "safety plan"—information about where to go and whom to contact to feel more secure.
- 2) Discuss what is being done and what will be done to help in the future. In the case of a disaster such as the hurricane, reinforce that while no one can predict the future, it is not likely that another hurricane will happen again.
- 3) Encourage children to express their feelings and listen without judgment. Allow children to cry, be sad, or be angry. Do not force expression of the traumatic event, but let children know that it is normal to feel upset, angry, or afraid when something bad happens.

4) Provide structure and routine whenever possible while being flexible to children's needs. Let children make some decisions about routines and other aspects of daily life to the extent that it is possible.

5) Realize that children who have lost a parent, sibling, relative, teacher, friend, or pet will need additional support and for a long period of time. Be aware that memories and feelings about these losses are recurrent and can be triggered by everyday images and reminders of the person or the hurricane, other events, holidays, or anniversaries.

6) Offer meaningful creative activities to encourage children to express their feelings and become active participants in their own process of recovery (see next section).

7) Be open to ongoing discussions. New questions and feelings develop over time. Look for opportunities to bring up issues and create an open environment that encourages children to talk about their concerns at any time.

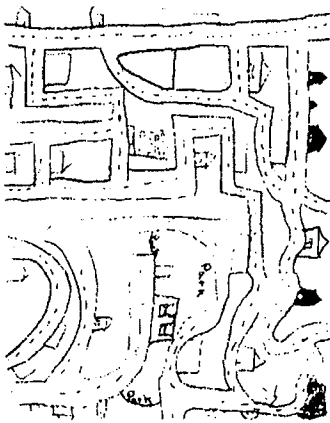
8) Be sure to manage your own feelings about the disaster or traumatic event. Take time to understand your own feelings and prepare yourself emotionally before you attempt to reassure or work with children.

9) Be sensitive to cultural differences among children who have experienced traumatic events or losses. For some children, expression of emotion or art making may not be acceptable or comfortable.

10) Help children and families feel connected to peers and adults who can provide support and decrease isolation. Be aware of local resources to help children and families obtain additional help if it is needed.

Art and Trauma Recovery in Children

In the aftermath of the events of September 11th, 2001, and the recent tsunami disaster in Southeast Asia, art expression has proven to be a very important part of the recovery process for children who have survived these traumatic events. Art offers a way for children to express their feelings, thoughts, and memories in ways that words



cannot. With guidance and support, it can help traumatized children to make sense of their experiences, communicate grief and loss, and become active participants in their own process of healing, beginning the process of seeing

themselves as "survivors" rather than as "victims."

For professionals using art activities with children, the experience of interacting with children who have experienced traumatic events may be a new one for you. The following guidelines may also be helpful in beginning your use of creative expression:

1) First, encourage children to express whatever they would like to express in their art. Some children also like to express themselves in other ways, such as in songs, stories, play, drama, or writing. Following a trauma it is important for children to be given choices. Because culture influences self-expression, some children may feel more comfortable with one way of expressing over another.

2) Keep in mind that a child's age, ability, personality, interest, and skill influence their creations.

The focus should be on the experience and process rather than the product.

3) Provide a safe and structured environment for creative expression to take place. Be empathetic, listen, encourage storytelling about art produced, and accept whatever is communicated about art created. Refrain from trying to interpret art and simply accept and encourage participation and self-expression. Engaging in a dialogue by simply asking a child to describe the elements in a picture can be helpful and supportive.

4) Use art activities to promote self-reliance and problem solving in children. Provide opportunities for experimentation with art materials, learning new art skills, and making decisions about what to draw, paint, or make during an art session.

5) Be aware that children may use art expression in a variety of ways after experiencing a traumatic event. Some children will repeat images of the event in their drawings, paintings, or play activities; others may resist memories of the actual event, preferring to use art activities to soothe and reduce stress. If

trauma stories are expressed, remain calm, listen, and respond without judgment or interpretation. It is

particularly important for you to normalize any feelings expressed by letting children know that what they are experiencing is being experienced by many other children, too.

6) Significant and personal feelings may be shared in the art making. It is important that children feel calm and in control at the end of an activity. Mak-



ing time to clean up or having a closing activity can be reassuring.

About Art Activities & Materials

Professionals who have not used art activities with children who have experienced trauma often wonder where to start. Using art in trauma recovery with children involves both non-structured and structured activities. Non-structured activities are those that encourage children to create from their imagination—in other words, to draw, paint, model, or build anything they would like. Many children already have ideas about what they would like to make in art and if they do, allow them to experiment freely with materials in safe and structured environment and enjoy the soothing and rewarding experience of creative expression. Try not to be tempted to draw or paint for them, but be attentive and supportive and provide help if the child does not know how to use a material, brush, or tool.

Other children, especially those who may be shy or withdrawn, may need a structured activity or theme to stimulate their participation and imagination. For example, you might ask the child to draw a picture of a "worry." Many children who have been traumatized have worries and fears since the tragedy happened. Making a picture of the worry or showing how big, what color, or what shape a worry is helps children to begin to identify fears and gives us a tangible image of what worries children find difficult to tell about with words. Use this as an opportunity to help the child find ways to express feelings through art—ask the child to show you through color, lines, shapes, or figures "what your worry looks like." "Safety" is another common issue that can be turned into a structured activity for art making. Help children to create a painting or drawing of a real or imaginary "safe place," where one can go in one's imagination when one is afraid or upset.

Wherever possible, it is helpful to have the following materials for creative expression:

Materials for drawing-- pencils, colored pencils, oil pastels/Craypas, felt pens, and paper. Drawing materials help children to express and tell stories and experiences because they allow for control and detail.

Materials for painting-- watercolor sets and tempera paints, and watercolor or card stock. Painting helps children express stories and experiences, but also encourages expression of feelings through color and brushstroke.

Materials for collage-- pre-cut magazine images, construction paper, tissue paper, string, yarn, glitter glue, and white glue. Collage is easy to control, provides structure, and stimulates the imagination.

Materials for modeling-- Model Magic, Play-Doh, plasticine, and water-based clay. Modeling with clay provides the opportunity to work in three dimensions and to rework and reconstruct.

Remember— not all children are familiar with art materials. Be sure to show them what each material can do. For example, teach children basic skills about how to hold a brush, how to mix paint, and how to apply it to a surface. Be sure to create a structured environment for creativity that is safe and supports children's freedom to express themselves through art.

To locate an art therapist, please visit www.arttherapistlocator.org, visit our web site at www.arttherapy.org, or contact us at:

**American Art Therapy Association, Inc.
5999 Stevenson Avenue
Alexandria, VA 22304
1-888-290-0878**

This monograph is based on information in *Healing Arts for Tsunami Survivors: Using Art Activities to Support Trauma Recovery in Children*, a joint publication of the International Children's Art Foundation (www.icaaf.org) and the American Art Therapy Association, Inc., January 2005.

Cohon, D., Hines, L., Cooper, B., Packman, W. & Siggins, E. (2003). A preliminary study of an intervention with kin caregivers. *Journal of Intergenerational Relationships*, V. 1, No 3. 49-72.

A Preliminary Study of an Intervention with Kin Caregivers

Don Cohon, Ph.D., Director
Lisa Hines, Senior Research Associate
Institute for the Study of Community-Based Services
Edgewood Center for Children and Families

Bruce A. Cooper, Ph. D.
California School of Professional Psychology

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Pacific Graduate School of Psychology, Palo Alto

Elizabeth Siggins, M. P. P.
Consultant, Senate Rules Committee
Sacramento

Acknowledgements

We gratefully thank the clients of Edgewood's Kinship Support Network who gave permission for our Institute staff to administer standardized questionnaires to them and to use information from their records in compiling this report. Our work also owes a great debt to the Kinship Support Network Community Workers who assisted Institute staff in establishing contact with kin clients. The Stuart Foundation of San Francisco provided the initial support for this study and continued to fund the major part of the work over five years. Additional support came from The Zellerbach Family Fund, The California Endowment, and The David and Lucile Packard Foundation.

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A Preliminary Study of an Intervention with Kin Caregivers

Abstract

This article presents descriptive and preliminary findings from a study of African American female kinship caregiver residents of San Francisco who received a case-managed supportive services intervention. After describing the methodology and instrumentation, we present characteristics of caregivers and children and then describe results that measured family needs, physical and mental health, and satisfaction with social support. Data from consumer satisfaction measures are also presented. The findings show decreased needs following the intervention and also improvement in general health and satisfaction with social support. Scores of clients' satisfaction with services were uniformly high. We discuss these results as they bear on other research and practice.

Key Words: kinship care; grandparenting; community-based services

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Introduction

In 1997, slightly more than one million children were identified as victims of substantiated abuse or neglect (Wang & Daro, 1998). The General Accounting Office reported that this increase, as well as the greater service needs of these children, has created a crisis in the nation's child welfare system (USGAO, 1995). Among factors contributing to this rise in numbers has been the growth in the use of crack cocaine (Minkler & Roe, 1993). One way the system has adapted to this crisis is by placing more children with relatives, particularly grandparents in the African-American community (Berrick, Barth, & Needell, 1994; Dubowitz, Feigelman, & Zuravin, 1993; Goerge, Wulszyn, & Harden, 1996; Minkler, Roe, & Price, 1992; Wilson & Chipungu, 1996). The women described in this report are part of this nationwide trend that has grown rapidly during the past decade—grandparents, or sometimes other extended family members, raising their kin children (Hegar, 1999; Hegar & Scannapieco, 1995). Nearly 5,435,000 children (7.7% of all children in the United States) were living in homes with a grandparent in 1997 (Bryson & Casper, 1999).

Although the child protective services system has increasingly relied on the informal kinship network as a resource for placing abused/neglected children removed from parental care, this system has not been able to offer much-needed support to these kin families (USGAO, 1995, 1998). One way the public sector has begun to provide services is by contracting with private agencies. Edgewood Center for Children and Families' Kinship Support Network (KSN) is an example of this trend (Cohon & Cooper, 1999; USGAO, 1997).

Health promotion and disease prevention activities in the elderly population are receiving increased attention, especially among the poor (Lubben, 1989). Other studies have shown that in a predominantly Caucasian sample, having a "custodial

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grandparenting" role (e.g., having parental responsibility) led to reduction in scores on measures of psychological well-being, grandparenting satisfaction, and satisfaction with the grandparent-grandchild relationship (Shore & Hayslip, 1994). Research specifically on the kinship caregiver population has also shown increased risk for physical and mental health problems (Kelley, Whitley, Sipe, & Yorker, 2000; Minkler, Fuller-Thomson, Miller, & Driver, 1997; Whitley et al., 2001). Additionally, when a grandparent assumes child-care responsibilities, dependence on friends or extended family is heightened (Shore & Hayslip, 1994). The importance of informal support networks among the African American elderly has been reported (Luckey, 1994).

KSN's primary mission is to provide San Francisco kinship families with comprehensive, case-managed services that fill gaps in and reduce barriers to accessing public services with the goal of decreasing caregivers' needs and improving their general health and satisfaction with support systems. To date there have been very few studies of interventions intended to improve outcomes for kin caregivers, and this preliminary study of KSN adds to the scant body of literature testing these supportive services interventions (Kelley, Yorker, Whitley, & Sipe, 2001).

KSN Intervention

In March 1993, Edgewood established KSN winning a contract from San Francisco's Department of Human Services (DHS). KSN is a private, non-profit, community-based service intervention with the public DHS acting as a "managed care" agency monitoring the program. The KSN model gives the public agencies (in this case, DHS and San Francisco Community Mental Health Services [SFCMHS]) sufficient oversight and controls to ensure that mandated policies are observed. KSN employs people from local neighborhoods who often are kin caregivers and who

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have shared similar life experiences with their clients. Services are delivered at a center-based site. Clients receiving case-managed services are assigned a Community Worker and receive a thorough assessment of their needs, a written case plan, direct intervention including minimum monthly home visits, weekly phone contact, and collateral visits to other service providers. The primary service intervention is with the caregiver, based on the theory that support for the caregiver benefits the children. The model is described in more detail elsewhere (Cohon & Cooper, 1999).

In addition to the case management intervention, ancillary services are available to families, including a variety of self-help support groups, recreation and respite activities, training workshops, tutoring/mentoring, health support, and transportation services. For 226 families who received case-managed services between August 1993 and December 1998, there were a total of 9044 hours of supportive services provided caregivers, with four major categories--1) Support Groups = 3438 hours; 2) Recreation = 3187 hours; 3) Training = 903 hours; and 4) Respite = 818 hours (involving 800 hours for summer camp). For 442 children in these families, 20,023 hours of support were provided as follows (major categories only): 1) Independent Living Skills (to teach skills for older children to live on their own) = 3245; 2) Respite = 3840; 3) Recreation = 5506; 4) Mentor/Tutoring = 2324; and 5) Mental Health Assessment/Counseling = 2094. It is important to point out that establishing these categories implies that they represent discrete units of service, but from a caregivers' or child's perspective, attending a support group, participating in independent living skills or going on a recreational outing could be considered as serving the same function.

For 344 inactive case-managed cases that had graduated or were closed, 31 % (n = 106) were closed within three months; 46 % (n = 158) were closed between three and 24 months; 16 % (n = 54) were closed between 24 months and 36 months; 8 % (n = 26) closed

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between 36 and 60 months. These case-managed families received a median number of 13 months of KSN services.

Methodology

Study Design

This is a descriptive evaluation study. Edgewood's Institute for the Study of Community-Based Services (Institute) collected basic demographic information for kinship caregivers and children who were clients of Edgewood's KSN. Because health has been found to be a particularly salient issue for caregivers (Berrick & Barth, 1994b; Berrick et al., 1994; Kelley, 1993; Kelley et al., 2001; Minkler et al., 1992; Whitley, Kelley, & Sipe, 2001), we thought it necessary to view caregivers' health within a broad context by comparing their scores on an established general health survey to national norms. The evaluation to assess the effectiveness of the KSN intervention on kin caregiver clients' needs, health status and satisfaction with support consisted of three measures given at intake (T1), a second time at graduation/closing (T2), and for some cases a third time six months later at follow up (T3).

Study Sample

This non-random sample consisted of kinship caregivers and relative children living in San Francisco who were referred for KSN case-managed services between July 1993 and March 1999. We attempted to enroll all referrals to the case-managed program, but a very small number of caregivers declined to participate for reasons of privacy. No formal criteria exist that define for DHS Child Welfare Workers (CWW) when to refer a kin caregiver family to KSN. To determine what factors CWWs considered when referring kin families, Institute staff interviewed six CWWs and their unit supervisor, asking an eight-item standardized set of questions. These questions focused specifically on considerations related to the caregivers, their children, and the DHS system with their responses reported here, but

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not rank ordered. The primary referral criteria for caregivers included their needs for: respite, someone to regularly talk with (which DHS staff acknowledged they were not able to consistently provide), advocacy and assistance in conducting business with other agencies, and emotional support. Referral factors related to the children included school problems, sometimes requiring tutoring, opportunities for children to socialize with other kids, a place to get clothes and food, counseling and mental health needs, transportation to appointments, and needs for stable routines and structure. CWWs reported system-related factors that influenced their referrals as follows: "huge" DHS case loads, limited comprehensive child support services at DHS, no DHS mental health services, family needs that required more time than DHS is able to provide, and KSN offering services at one location.

The high number of African-American clients resulted in sample sizes for other ethnic groups that were too small for meaningful statistical analyses of data. Because of this limitation, we selected only African American families for this study, applying the following inclusion criteria to study participants: new to the KSN case-managed program, African American, San Francisco resident, former clients of KSN's non case-managed services who were entering case-managed services for the first time. We eliminated caregivers from the study assessment panel if they received less than six months of the intervention, although their demographics are included in the description of client characteristics.

Between KSN's 1993 opening and March 1999, the program provided case-managed services to a total of 424 families of which 221 were dependent and 203 non-dependent. For this study, a family having one child or more involved with DHS Child Protective Services (CPS) who has been made a dependent of the San Francisco Juvenile Court is considered a dependent case even though there may be non-dependent kin children residing in the same home. Table 1 shows descriptive data for all primary caregivers seen in the case-managed

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program during this time and reports all ethnic groups who were clients, although as noted, we only selected African Americans for the study sample. Eighty of these 424 families were active KSN cases and 344 were inactive, having graduated or closed.

[INSERT TABLE 1 ABOUT HERE]

Not surprisingly, age was related to caregivers' relationship to the kin children (e.g. grandparents were older than aunts). We separated caregivers into three age groups: 1) Non-grandparents, median age of 37 (n = 89); 2) Grandparents, median age of 55 (n = 266); and 3) Great- or Great-great grandparents, median age of 68 (n = 25). We examined familial relationships of kin with an unduplicated count, and found that 54% (223) are maternal grandmothers; 1% (6) are maternal grandfathers; 12% (49) are paternal grandmothers; 1% (3) are paternal grandfathers; 12% (50) are maternal aunts; 5% (22) are maternal great-grandmothers, and 1% (3) are maternal great-great grandmothers. These women fill multiple roles in these families, often having several types of extended family relationships with the children for whom they care. Caregivers reported that they had been raising their kin children from as short as several weeks to as long as 17 and one half years, with a median of four years and five months of active caregiving.

The total number of children in these KSN case-managed families was 868 of whom 47% (404) were dependents of the court and 53% (464) were non-dependents; 51% (443) were female. The number of kin children living with each caregiver ranged from one to eight, with a median of two children per family. Within the calendar year prior to their KSN intake date, only 4% of children (37) had received Special Education services, which is below the statewide average. Importantly, only forty-five percent (388) had received a physical examination in the year prior to KSN intake. See Table 2.

[INSERT TABLE 2 ABOUT HERE]

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Assessment Measures

Because of their clinical and theoretical relevance to the kinship caregiver population, instruments selected for the assessment tapped three areas of concern: 1) family needs; 2) caregivers' physical and mental health; 3) caregivers' satisfaction with their social support network. In addition to these three instruments, we regularly obtained an additional measure of client satisfaction with different aspects of the KSN program, and these data are also reported.

Family Needs

Determining need(s) is a first step in establishing client goals. A needs assessment based on Dunst, Trivette & Deal's Family Needs Scale (1988) was adapted for use with kin caregivers, as both a clinical tool and evaluation measure, forming the basis for developing the family case plan. It is also administered at graduation to assess changes in expressed needs during the life of a KSN case. The original measure contained 41 items such as: "Having money to buy necessities and pay bills"; and "Having enough food daily for two meals for my family." Respondents were given three choices: "Never," "Sometimes," or "Almost Always." After nine months of use, the needs items were analyzed for frequency of response. Ten items that were not yielding useful data were eliminated, and we continued to use a 31-item measure.

Physical and Mental Health

A measure of general health and mental health was sought that did not overly burden KSN client respondents. The SF-36 Health Survey (Ware & Sherbourne, 1992; Ware, 1993) is a 36-item self-report measure with eight multi-item health scales containing two to ten items each: Physical Functioning; Role-Physical (limitations due to physical health problems);

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Bodily Pain; General Health; Vitality; Social Functioning; Role-Emotional (limitations due to emotional problems); and Mental Health. The items are summed to form Likert scales with higher scores indicating better health status. Researchers have found validity and reliability with the SF-36, exceeding accepted standards for group comparison measures (McHorney, Ware, Lu, & Sherbourne, 1994; Ware, 1993).

Satisfaction with Social Support

A social support measure based on previous work with maternal stress was included as part of the assessment panel (Crnic, Greenberg, Ragozin, Robinson & Bashram 1982). The modified KSN version contains questions about available support from intimates, friends, and community, as well as respondents' satisfaction with that particular type of support, rated on a four-point Likert scale from "Very Dissatisfied" (1) to "Very Satisfied" (4).

Consumer Satisfaction

Finally, Institute staff regularly use brief consumer satisfaction measures to provide feedback to program staff about community workers and specific components of KSN services. Simple instruments were designed using the format of school report cards, asking respondents to "Give us a grade." The grading system is ordered A, B, C, D, and F, and transforms to a five-point scale with the highest score equivalent to a 4.0 and the lowest a zero. The Report Cards assign grades to Intake Worker and Services (five items), Community Workers (eight items), and Overall Agency Services (five items).

Procedures

Institute staff obtained new client information from the Intake Workers (IW), who completed the Family Needs Scale and obtained an Informed Consent form for participating clients. Interviews were conducted within two weeks of intake or prior to the client receiving

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services (T1). Participating caregivers were paid \$20 for each completed interview. Cases that received more than six months of case-management services had a second assessment at graduation or closing (T2) with the Family Needs Scale, the SF-36 and the Crnic and Greenberg satisfaction with support measure. Six months after this graduation/closing interview, Institute staff administered the measures a third time with all available clients (T3), although contacting caregivers proved particularly challenging as many had moved or their phone numbers had changed. Institute staff regularly collected consumer satisfaction Report Cards from caregivers.

Limitations

Because our sample was selected from KSN clients, it does not represent a general population nor were they randomly assigned, and therefore, it is not possible to generalize to all kin caregivers. Because Dunst's instrument was used also for clinical purposes, we changed the scoring to make it easier for older caregivers, utilizing a 3-point scale. A scale with such a short range yields changes from T1 to T2 that are not numerically substantial, and caution should be used when interpreting item reductions. As with other researchers who have studied grandparent caregivers (Johnson, 1995; Minkler & Roe, 1993), we knew that we were outsiders to the lives of the women in our study. Although the Institute staff who conducted the interviews were African American women like the respondents, their status as part of a research team, not having personal experience raising children, and their younger age, may have influenced caregivers' responses.

Findings

Family Needs Scale (FNS)

An analysis of scores on the FNS was performed using the Wilcoxon Signed-Ranks test for 122 kin caregivers who graduated from the program. This analysis compared the

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same 122 cases' FNS responses at two points in time, intake (T1) and graduation (T2), and looked at people who changed in either a positive or negative direction after receiving KSN services. A positive direction is expressing less need, and a negative direction is expressing more need at the time a client graduates. These 122 caregivers reported less need at graduation (T2) for 30 out of 31 needs (97%). The only need not showing a reduction over time was item number 35, "Assistance with alcohol or other substance abuse problems either for myself or family member (specify)." As noted, numeric differences with a 3-point scale are slight, ranging from .3 to .5 for the 30 items showing less need at graduation. Nevertheless, it is particularly noteworthy that these 122 individuals, consistently reported reduced levels of need after KSN's intervention.

In a separate analysis, we rank ordered scores of the needs at intake (T1) and again at graduation (T2) and found that, although people reported less need at T2, the same needs continued to be present and in roughly the same order (See Table 3). This relationship of needs from T1 to T2 has a Spearman correlation on ranked means of .87, showing substantial overlap. For example, having adequate finances as well as needing time for themselves remain important needs for these women.

[INSERT TABLE 3 ABOUT HERE]

Of significance, this analysis of mean ranks showed an intriguing shift towards increased need at graduation (T2) to plan for the future evidenced by the shift of assistance with managing money (from rank 16 to 9) and legal affairs (from rank 15 to 10). There is also a lessening of need for services focusing on the children, such as having someone to talk with about a child (from rank 10 to no longer in top 16 needs at T2), transporting the child (from rank 7 to 15), finding emergency child care (from rank 8 to 12), or obtaining special services for a child (from rank 5 down to 13).

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SF-36 Health Survey (SF-36)

We thought it important to place the health status of this sample of caregivers within the context of national norms for this measure. These national norm groups have 15% African American and 12% low income as part of their make-up and were compared with those of the general U. S. population published by the National Center for Health Statistics. Results support the representativeness of the norming sample for the SF-36 (Ware, 1993). Because the median age of KSN grandparents is 54, means for females in the SF-36 normative age groupings 45-54 (sample $n = 193$) and 55-64 (sample $n = 164$) were combined by calculating a weighted mean for females ages 45-64 for comparative purposes.

One hundred thirty-four kinship caregivers in the case-managed program completed the SF-36 soon after intake. Only two males were in this group and were dropped from these analyses, which utilized national norms only for females. Since increased age is typically associated with poorer health and role limitations, we created two caregiver groups for analysis: 1) Grandmothers, Great Grandmothers, and Great-Great Grandmothers ($n=96$) and 2) Non-Grandparents younger than 45 ($n=36$). Transformed KSN mean scores on a scale of 0 to 100 for 96 grandmothers, great grandmothers, and great-great grandmothers compared with the normative sample grouping revealed statistically significant lower scores for these older caregivers on all eight scales of the SF-36 (See table 4.).

[INSERT TABLE 4 ABOUT HERE]

For non-grandparent females under age 45, we used SF-36 normative mean scores for females ages 35-44 ($n = 264$) for comparison. This analysis showed that the KSN group of younger, non-grandparent females were significantly healthier in General Health ($p < .001$) and Bodily Pain ($p < .05$) and no different on any other of the SF-36 scales than the normative comparison group mean scores (See table 5.).

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[INSERT TABLE 5 ABOUT HERE]

In addition to comparing these two groups of caregivers to the SF-36 norms, we performed independent group, separate variance t-tests on SF-36 scores at intake for 96 grandparents, great or great-great grandparents and 36 non-grandparents. We found significant differences on all eight of the SF-36 scales with the grandparent group doing much worse than the non-grandparent group. Because the sample size is large, which may more readily produce statistical differences, we examined the effect size of the difference using Cohen's "d." We found on all eight subscales a medium to substantial effect size, confirming that the grandparent group of older women is doing much worse both physically and emotionally than the non-grandparent group.

Because we had difficulty in locating individuals for follow-up interviews at both T2 and T3, we performed repeated measures t-tests for only 35 KSN female clients, combining both grandparents and non-grandparents, from initial (T1) to graduation (T2), and no significant differences were found. However, five of the eight SF-36 scales did show non-significant improvement (See table 6.). Similar t-tests were done for 18 women from graduation (T2) to follow-up, six months after graduation (T3), and no significant differences were found, although social functioning was maintained at this follow up.

[INSERT TABLE 6 ABOUT HERE]

Satisfaction with Social Support Measure (SSM)

The SSM was completed at intake by 118 caregivers, excluding cases that closed prematurely or were non-compliant. Responses indicated that they were more than somewhat satisfied with the support they receive rated on a 4-point scale (1 = Very Dissatisfied and 4 = Very Satisfied). They rated general support highest at a mean of 3.6, followed closely by satisfaction with family support (M = 3.4) and then friendships (M =

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3.2). Satisfaction with support from their community was rated least favorably ($M = 2.8$).

Paired differences t-tests for 36 KSN graduates from intake (T1) to graduation (T2) found significantly more satisfaction at T2 with support from friends ($p < .05$) and with general support ($p < .05$).

Consumer Satisfaction Report Cards

From the client perspective, there was a widespread consensus about the significance of case-managed KSN services, especially the support and availability of the Community Workers. Report Card data indicated that 196 clients gave the Intake Worker and Process a grade of 3.81, with 85% of the caregivers giving an "A" to this service component. Community Workers received a 3.85, and 90% of clients graded the community workers "A." General KSN Services got a 3.80 with 84% of caregivers assigning an "A" to the case-managed services they had received. Clients' comments reflected the uniformly high scores given on the Consumer Satisfaction Report Cards, as this grandmother indicated.

They are supportive, number one, very supportive. Someone I can always talk to. They always know. The worker I have had there, Ms. D, she can sense when something is wrong with one of her grandparents. And she always calls and checks on you, and asks how you are, if there is anything she can do. And the interesting thing about her is that she is a grandmother, a foster grandmother, herself. And she's really concerned about us, out here. And there's Ms. B who does the school-based along with her, and she's always calling and checking and on C's school, and making sure that's up to par. And always calling and asks if there is anything she can do. Her and Ms. D both, if I need a ride to an appointment or something, they are always willing to help me out. They have been a godsend.

Discussion

The KSN model incorporates recommendations for intervention services made by other researchers of this kinship caregiver population (Davidson, 1997; Gleeson & Hairston, 1999; Kelley, 1993; Minkler & Roe, 1993; Roe, 2000). It also reflects the guidelines for services to special populations generally, which recommend that interventions be

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comprehensive, community-based, sensitive to each locale's context and history, and client/family-focused (Besharov & Laumann, 1997; Finnegan & Kandall, 1992; McAuley, 1998).

DHS CWWs indicated that the criteria they used in referring a kin family to KSN included needs of the caregiver and child that the public sector could not adequately address. They noted that there were "huge" caseloads and generally confirmed other studies of the foster care system that found its capacity to provide services significantly strained (USGAO, 1995). While the present study did not compare permanency outcomes for children with a DHS sample of children, several findings are worth noting. Of the 424 kin families seen during the study period, only 4% ($n = 14$) of the children were reunified with their biological parent(s). Drug use, especially involving crack cocaine, has played a significant part in disrupting many of these families and led to increased placement of children with kin (Minkler & Roe, 1993; USGAO, 1998). This four percent reunification rate may reflect difficulties in successfully rehabilitating crack cocaine users. It may also be an indication that these families are comfortable having extended family members raising children and that this informal structure is an acceptable alternative to the public sector's formal definition of permanency (Brown, Cohon, & Wheeler, 2002). Another outcome of note is that 6% ($n = 19$) children were removed from their kin caregivers' because of concern for their safety and/or the caregivers' inability to continue raising children due to physical or mental health, sometimes involving their own substance abuse. Although the use of kin homes as placement alternatives to regular foster homes has been increasing, it is important that these relative placements are monitored regularly using public CPS standards for protection of the child(ren), while recognizing and accounting for cultural differences (Berrick, 1997; Scannapieco & Hegar, 1996b).

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With respect to the KSN intervention, families were active cases on average for a little more than one year. About one third of the cases were closed within three months, suggesting that a group of families had acute needs that resolved quickly or perhaps did not avail themselves of KSN services. A small number of families remained active for more than three years, some as long as five years, suggesting chronic needs that required ongoing case management. Each family received various ancillary services, and the number of hours of service ranged from very few to a large number. We urge caution in attempting to draw conclusions about the affects of specific services such as respite in contrast to recreation versus attending support groups or participating in mental health/counseling sessions. For example, in the counseling process, the literature notes the importance of client and counselor variables such as social class, personality, diagnosis, age, gender, ethnicity, and intelligence in addition to counseling-specific factors such as professional background, therapeutic style, therapeutic interventions, relationship attitudes, and expectations (Beutler, 1993; Garfield, 1986). These multiple factors interact with internal biochemical processes of both client and counselor in multiple ways on particular occasions in different contexts. Such complexity makes effective measurement of process and outcome in any treatment situation, sometimes referred to as the dosage or potency of a treatment, a challenging goal. Additionally, accounting for the number of hours provided for each type of service demands accurate and detailed record keeping, which KSN Community Workers felt added significantly to staff duties and detracted from delivery of services. We believe that giving caregivers the option to select from a number of supportive services allowing them to match their individual needs with a particular services at a given point in time is the important element in the KSN model.

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Women endorsed high levels of need at Intake to KSN, especially for respite and the need to have time for themselves. Family Needs Scale findings from the assessment panel are quite striking. Between intake (T1) and graduation (T2), 122 KSN graduates report significantly lower levels of need on 30 of 31 items (97%). The only need not showing reduction was related to alcohol and substance abuse, and we believe caregivers were reluctant to express this need because they might risk removal of their children. It is clear from the scores that there is a consistent reduction in expressed need following the KSN intervention, although the same needs remain present. There is also a change in the rank order of needs at graduation with greater expression of needs to plan for the future to ensure continuity for the children. Positional changes of items on the FNS may reflect one way in which the KSN intervention contributed to a growing awareness of caregivers to recognize their age and mortality. By endorsing these items, caregivers are acknowledging the need to plan financial and legal matters, such as preparing a will, that affect their children's futures. This suggests that the KSN intervention has contributed to a positive outcome for clients assisting them prepare for changes in their circumstances that may affect the children.

Caregivers identified the need for money simply to buy necessities and pay bills as highly significant and ranked this as the number one need at T2. For this sample, living in San Francisco, one of the most expensive housing markets in the nation, may create some unique financial challenges. But even for the general population of grandparent caregivers, money is a significant problem. In 1997, 27% of children living in grandparent-headed households (may have two grandparents) were impoverished, and two thirds of children living in grandmother only-headed households were living in poverty (Casper & Bryson, 1998). Financial problems were identified in prior studies on grandparents in this caregiving role (Szinovacz, DeViney, & Atkinson, 1999). Grandparents acting as parents were found to

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have significantly more "serious financial difficulties or problems" when compared with combined spouse and adult-child caregivers (Strawbridge, Wallhagen, Shema, & Kaplan, 1997).

Women in our sample have had difficult life experiences and, after becoming surrogate parents, expectably might have more negative than positive consequences to their health and well-being. At intake a group of older grandparents reported significantly worse health than a non-grandparent group on all eight SF-36 scales. Furthermore, these older grandparent caregivers reported very poor health compared to other women of similar age in a national norm group. This suggests that for these older women, caregiving for kin children may have a negative effect on physical and mental health compared with a similarly aged non-parenting group of women. However, it is important to recall that these women do not represent the general population and in fact have been referred to KSN based on clinical decisions that they have significant needs, including health and mental health. In contrast, the non-grandparent group of KSN caregivers indicated that they were as healthy or even significantly healthier on two SF-36 subscales (General Health and Bodily Pain) than a national norm group of similarly aged women. The comparative healthiness of younger caregivers supports the proposition that taking on parenting responsibilities may contribute to poorer physical and mental health for older women because the added burden of raising children occurs at a time in their lives when aging processes may make them less fit or able to cope.

Several recent studies using national data sets found both positive and negative effects of surrogate parenting (Giarrusso, Silverstein, & Feng, 2000; Szinovacz et al., 1999). Other research of non-representative samples of kin caregivers has generally reported poor health status (Burton, 1992; Fuller Thomson, Minkler, & Driver, 1997; Kelley, 1993; Kelley

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et al., 2000; Strawbridge et al., 1997; Whitley et al., 2001). The data in our study add to this growing body of literature that shows physical and mental distress experienced by older caregivers. Certainly, it is not possible to attribute negative health or well-being to a single event such as becoming a surrogate parent because these women have experienced multiple stressors that are cumulative, and interactive. As Johnson (1995) noted, the urban poor grandmothers in his sample were “no strangers to sorrow” (Pg. 100). There is a much greater likelihood of negative consequences for women in families whose lives are already difficult, socially and financially. After reviewing findings from prior research and including the data from the present study, we conclude that there are more negative than positive effects on health and well-being after assuming this role and that individual women experience both in different degrees at different times.

Repeated measures analyses of a group of KSN graduates (n=36) found that they reported significantly more satisfaction with Support From Friends and with General Support at time of graduation than at intake. This suggests that KSN’s intervention, which offers a close relationship with a Community Worker as well as opportunities for increased contact with other caregivers, contributed to these women reporting more satisfaction with the support they received, especially from friends. We recommend that programs working with the kin caregiver population include services designed to strengthen clients’ social support, which has been suggested in other research (Kelley et al., 2000).

Finally, consumer satisfaction instruments in the form of school report cards showed uniformly high grades for three aspects of the KSN program—Intake, Community Workers, and General Agency Services. Although there appeared to be little discrimination in the grading done by caregivers, we think that soliciting feedback about services is important and gives clients an opportunity to comment and offer suggestions on improving services.

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Conclusion

A case-management intervention offered by a person whose background resembles their clients in combination with tangible assistance such as food, clothing or furniture, and sometimes including other supportive services such as respite, recreation, health, mental health, support groups, and child-focused activities significantly reduced needs for these African American female caregivers. These women also indicated increased awareness of planning for the future (e.g. financial and legal issues) at the time of their graduation from services. The health of older caregivers in this group appeared to be negatively affected by assuming the surrogate parent role, although it is not possible to attribute their poor health status solely to taking on this task because of other social determinants affecting their lives such as poverty and environmental factors. Regardless of this uncertainty with respect to etiology, programs serving similar populations should provide services to address caregivers' physical and mental health.

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APPENDIX A

Tables

Table 1. Caregivers' Demographic Variables					
VARIABLE	ACTIVE	%	INACTIVE	%	TOTAL
Dependent Caregivers	39	18%	182	82%	221
Non-dependent Caregivers	41	20%	162	80%	203
Total	80	19%	344	81%	424
Gender					
Male	2	15%	11	85%	13
Female	78	19%	331	81%	409
Gender Unidentified	0	0%	2	100%	2
Ethnicity					
African American	64	19%	279	81%	343
Latino/Other Hispanic	8	29%	20	71%	28
Filipino/Pacific Islander	1	50%	1	50%	2
Native American	2	40%	3	60%	5
Caucasian/White	3	16%	16	84%	19
Other/Bi-Multi Racial	2	40%	3	60%	5
Ethnicity Unknown	0	0%	22	100%	22
Age					
Median Age	54		54		
Non-Grandparents	38		37		37
Grandparents	55		55		55
Great and Great-Great GP	69		68		68
Other					
Median Number of Years of Education	12		12		12
Median Number of Years of Caregiving	2.9		4.4		4.1
Median Number of Children in Home	2		2		2
Range of Number of Children in Home	1-7		1-8		
Median Number of Years of KSN service			1.1		1.1

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Table 2. Children's Demographic Variables by Caregiver Classification*

VARIABLE - CASES	ACTIVE DEP		INACTIVE DEP		ACTIVE NON-DEP		INACTIVE NON-DEP		TOTAL
Children within cases		%		%		%		%	
Dependent Children	70	17%	334	83%	0	0%	0	0%	404
Non-dependent Children	16	3%	91	20%	72	16%	285	61%	464
Total	86	10%	425	49%	72	8%	285	33%	868
Gender									
Male	36	8%	213	50%	34	8%	141	33%	424
Female	50	11%	211	48%	38	9%	144	33%	443
Age Missing			1						1
Ethnicity									
African American	62	8%	391	54%	60	8%	217	30%	730
Latino/Other Hispanic	5	10%	17	33%	6	12%	24	46%	52
Filipino/Pacific Islander	0	0%	2	100%	0	0%	0	0%	2
Native American	0	0%	0	0%	1	33%	2	67%	3
Caucasian/White	0	0%	5	45%	2	18%	4	36%	11
Other/Bi-Multi Racial	16	67%	1	4%	2	8%	5	21%	24
Ethnicity Unknown	3	7%	9	20%	1	2%	33	72%	46
Age in Years									
0 through 1	1	8%	2	15%	5	38%	5	38%	13
2 through 3	6	17%	9	26%	6	17%	14	40%	35
4 through 8	31	13%	90	39%	29	13%	81	35%	231
9 through 12	36	13%	137	49%	21	8%	83	30%	277
13 through 18	12	5%	148	59%	11	4%	79	32%	250
19 through 21	0	0%	35	67%	0	0%	17	33%	52
Missing	0	0%	4	40%	0	0%	6	60%	10
Other									
Receiving Special Education	3	8%	57	154%	3	8%	19	51%	37
Involved with Juvenile Court	0	0%	3	100%	0	0%	0	0%	3
Physical Exam in Last Year	48	12%	206	53%	30	8%	104	27%	388

* Caregivers are classified by Activity Status of Active or Inactive and as Dependent or Non-Dependent depending on whether they have children living with them who are dependents of San Francisco Juvenile Court. Any caregiver caring for a dependent child is classified as Dependent. Caregivers classified as Dependent may have Non-Dependent children living with them. Four families had dependent children who were removed or closed and these cases were re-classified as Non-Dependent. One of these families was reactivated.

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Table 3. Top sixteen ranking FNS item's Mean scores at Intake and at Graduation				
Rank	Need Item # at Intake (T1)	Mean at Intake	Need Item # at Graduation (T2)	Mean at Grad
1	29. Getting respite care.	2.074	1. Having money to buy necessities and pay bills.	1.672
2	23. Having time to do things for myself.	2.006	23. Having time to do things for myself.	1.656
3	1. Having money to buy necessities and pay bills.	1.926	33. Participating in parent groups or clubs.	1.574
4	11. Getting furniture, clothes, toys.	1.871	29. Getting respite care.	1.533
5	30. Getting special services for my child such as counseling, special education, vocational training.	1.857	11. Getting furniture, clothes, toys.	1.459
6	33. Participating in parent groups or clubs.	1.816	25. Planning for my own future health needs.	1.451
7	18. Transporting my child places including appointments.	1.765	32. Doing fun things with my family.	1.426
8	28. Having emergency child care.	1.765	16. Getting places I need to go for myself.	1.393
9	21. Having someone to talk to about how things are going for me.	1.755	2. Budgeting money.*	1.377
10	20. Finding someone to talk to about my children.***	1.732	5. Legal assistance. *	1.369
11	16. Getting places I need to go for myself.	1.728	21. Having someone to talk to about how things are going for me.	1.361
12	32. Doing fun things with my family.	1.706	28. Having emergency child care.**	1.361
13	34. Learning how to be a more effective parent.	1.652	30. Getting special services for my child such as counseling, special education, vocational training.**	1.352
14	25. Planning for my own future health needs.	1.644	12. Completing chores, repairs, home improvements.	1.352
15	5. Legal assistance.	1.639	18. Transporting my child places including appointments.**	1.336
16	2. Budgeting money.	1.623	34. Learning how to be a more effective parent.	1.336
* = increased @ T2; ** = decreased @ T2; *** decreased @ T2 below the top 16 item mean ranks				

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Table 4. 96 KSN Female Grandmothers, Great Grandmothers and Great-Great Grandmothers Compared to Norm Group Females, ages 45-64, on SF-36 Scales								
SF-36 General Health Survey Scales ^a								
FEMALES	Phys. Funct	Role-Phys.	Bodily Pain	Gen. Health	Vitality	Social Funct	Role-Emot	Ment. Health
KSN Means	62.9	48.5	49	58.7	47.2	68.1	53.7	64.7
KSN SDs	29.2	43.79	31.44	24.61	24.07	32.86	40.8	23.28
Norm Means (Ages 45-64)	78.0	75.8	69.4	66.7	59.4	81.1	81.7	73.9
t-statistic	-4.65 ***	-5.32 ***	-6.06 ***	-3.04 ***	-4.82 ***	-3.73 ***	-6.30 ***	-3.94 ***
*p < .05, **p < .01, ***p < .001, 97 df, two-tailed. ^a Lower scores mean poorer health								

Table 5. 36 KSN Female Non-Grandmothers Younger than age 45 Compared to Norm Group Females, ages 35-44, on SF-36 Scales								
SF-36 General Health Survey Scales ^a								
FEMALES	Phys. Funct	Role-Phys.	Bodily Pain	Gen. Health	Vitality	Social Funct	Role-Emot	Ment. Health
KSN Means	88.8	86.1	83	83.2	60.4	83	75	72.1
KSN SDs	17.4	27.7	23.2	17.3	19.7	25.2	39.3	16.6
Norm Means (Ages 35-44)	88.1	83.7	74.9	74.3	59.4	83.1	80.1	73.3
t-statistic	1.04	0.92	2.42 *	3.57 ***	0.30	0.08	-0.83	-0.48
*p < .05, **p < .01, ***p < .001, 97 df, two-tailed. ^a Lower scores mean poorer health								

Table 6. 35 KSN Female Grandmothers and Non-Grandmothers Paired Differences t-tests @ T1 & T2								
SF-36 General Health Survey Scales ^a								
FEMALES	Phys. Funct	Role-Phys.	Bodily Pain	Gen. Health	Vitality	Social Funct	Role-Emot	Ment. Health
T1 Means	66.3	45.7	51.4	59.6	45.9	63.9	53.3	64.6
T1 SDs	26.5	45.2	35.2	24.6	22.2	32.3	39.8	21.7
T2 Means	62.4	54.3	51.5	64	45	70.7	66.7	68.1
T2 SDs	30.5	44.3	32.5	24.2	24.5	33.3	46.4	16.9
^a Lower scores mean poorer health								



23 February 2009

Honorable Congresswoman Jackie Speier
United States Congress
12th Congressional District

Dear Congresswoman Speier:

I send this letter with enthusiasm about the possibilities of Friends of the Children San Francisco (www.fotcsf.org) developing a true collaboration with Edgewood Center for Children and Families on behalf of countless fragile, vulnerable, at-risk children in San Francisco and San Mateo Counties. Our programs are different in the ways we provide services; however, we are aligned closely in our commitment. By planning and working together, I believe Edgewood and Friends of the Children San Francisco will be strengthened. With that strength, children and families will be able to access important services including tutoring, counseling, mentoring, and physical activity. Indeed, our communities will be strengthened by the collaboration.

On behalf of the children and families served by Friends of the Children San Francisco and Edgewood Center for Children and Families, I sincerely thank you for your interest and support.

Sincerely,

Charlotte E. Burchard
Executive Director



ODC / San Francisco:

Lori Laqua, *Managing Director*

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March 2, 2009

Congresswoman Jackie Speier
12th Congressional District of California

Dear Congresswoman Speier:

We are pleased to write this letter to you about our collaboration with Edgewood Center for Children and Families as they seek to expand their ability to provide art and therapeutic recreation to high risk children and their families.

San Francisco and San Mateo communities rely on Edgewood to provide services to the families and the children that we all care so deeply about, those at risk for failure in our schools, in the community and in their lives in general. ODC has been collaborating with Edgewood teaching dance to children on their Vicente campus. This past holiday season we were so pleased to feature two Edgewood kids in our signature children's performance *The Velveteen Rabbit* at the Yerba Buena Center for the Arts. Not only was the addition of these children special to the kids and their families, but it was equally as memorable for our company and the general audience at large. It was a wonderful synergy.

We are true believers that art has a tremendous healing power. Assuring that children have access to art, dance and other creative activities is the challenge that Edgewood is working to overcome.

With your help we can all work together to make sure that every child truly gets a chance at a bright future no matter what community they come from, or what difficulties they may be dealing with.

Thank you so much for your terrific work on behalf of San Francisco and San Mateo.

Sincerely,

KT Nelson

Co-Artistic Director
ODC/Dance